Region 7 COVID-19 Face Mask/Cloth Face Covering Waiver Request Form

As a result of the COVID-19 pandemic, the use of face masks or cloth face coverings is required at all Region 7 school districts. District employees and/or students may request a waiver to this requirement from their healthcare practitioner. All waiver requests will be reviewed and either approved or denied by the Health Officer of the appropriate county.

Requestor

First Name: ______________________ Last Name: ______________________ DOB: ________________

Health Care Practitioner Declaration

I declare that use of face mask or a cloth face covering is not advisable for this requestor. I have discussed the benefits and risks of face masks/cloth face coverings with the requestor (or parent/guardian) as a condition for requesting this waiver. I have either identified an alternative droplet retention method or no alternative method/exclusion.

1. Medical Diagnosis (Required) __________________________________________________________
   Additional Details: ___________________________________________________________________
   __________________________________________________________

2. Alternative Droplet Retention Method (Required): ________________________________________
   __________________________________________________________ OR □ No Alternative. Recommend Exclusion.

I certify I am a qualified MD, ND, DO, ARNP or PA licensed in Washington State and the information on this form is complete and accurate.

Licensed Health Care Practitioner Name (print) ______________________ Licensed Health Care Practitioner Signature ______________________ Date ________________

□ MD □ ND □ DO □ ARNP □ PA Washington License # ______________________

Cell phone where Health Officer may reach you: ______________________

Health Officer Review

I have reviewed the request and the recommended alternative. □ Approve Waiver □ Deny Waiver

Additional Detail: _________________________________________________________________

Health Officer Name (print) ______________________ Health Officer Signature ______________________ Date ________________

Washington License # ______________________

Region 7: Chelan-Douglas, Grant, Okanogan, Kittitas County Health Districts ______________________ Date: 8/12/20